ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
PROVIDER REGISTRATION FORM

SHADED FIELDS FOR AHCCCS PROVIDER REGISTRATION STAFF ONLY *Please Type or Print in Ink*

SECTION I

1) PROVIDER ID NO (Complete Only if you are currently registered and have a Group Provider No)	PROVIDER NPI (NATIONAL PROVIDER IDENTIFIER) NUMBER (if applicable)	
2) PROVIDER NAME(Enter the company name)		
	7) FFS TYPE	8) IHS INDICATOR
9) APPLICATION DATE Month ____ Day ____ Year ____	10) FIRST DATE OF SERVICE FOR WHICH A CLAIM WILL BE SUBMITTED Month ____ Day ____ Year	

SECTION II ADDRESS INFORMATION

CORRESPONDENCE ADDRESS (Enter the address to which all correspondence other than payments are to be mailed)

ADDR C SITE 01

11) STREET LINE 1: _____

12) STREET LINE 2: _____

13) CITY/STATE/ZIP: _____

14) COUNTY CODE: _____

15) BUSINESS PHONE: (____) ____ ____ 16) EMERGENCY PHONE (____) ____ ____

17) ATTENTION TO: _____

PAY-TO ADDRESS (Enter the address to which payments are to be mailed)

ADDR P SITE 01

11) STREET LINE 1: _____

12) STREET LINE 2: _____

13) CITY/STATE/ZIP: _____

14) COUNTY CODE: _____

15) BUSINESS PHONE: (____) ____ ____ 16) EMERGENCY PHONE (____) ____ ____

17) ATTENTION TO: _____

18) EMPLOYER TAX ID: _____

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SECTION III Authorized Signature This section is optional. Completion of this section authorizes representatives to act as a signor for the group with regard to AHCCCS claims and correspondence. The authorized representative must sign below with their usual signature. Please note for the initial registration process the CEO, CFO or Administrator of the organization must sign this registration form. The authorized signor can sign the Provider Participation Agreement.

Signature:_____ Print Name:_____ Begin Date:_____

Signature:_____ Print Name:_____ Begin Date:_____

Signature:_____ Print Name:_____ Begin Date:_____

Completion of the following questions is mandatory

Has the practice/organization that you represent or any of the signatories listed above ever applied for or received an AHCCCS provider identification number under any other name than noted on this form?

☐ NO

☐ YES (Please explain)

Has the practice/organization that you represent or any of the signatories listed above ever been terminated, suspended, advised of any deficiencies or otherwise subject to any corrective or disciplinary action by a governmental body?

☐ NO

☐ YES (Please explain)

I affirm under penalty of law that the information I have provided on this form is true, accurate and complete to the best of my knowledge.

48) _____
PROVIDER SIGNATURE (ONLY)

49) _____
DATE

50)
PROVIDER NAME (PLEASE TYPE OR PRINT)

Reset Form